An audit of operative notes in general surgery at Pakistan Institute of Medical Sciences (P.I.M.S.), Pakistan. Do we follow the Royal College of Surgeons (England) guidelines?

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Abstract

Objectives: To evaluate operative notes in the light of a standard guideline, and to establish a new more precise proforma for future documentation.

Method: The retrospective study was conducted at the Pakistan Institute of Medical Sciences, Islamabad, Pakistan, and comprised audit of consecutive General Surgery elective operation theatre notes from October 2015 to November 2015 according to Royal College of Surgeons (England) guidelines 2014. After the audit, all the doctors were educated about the completion of operation notes and an experimental operation notes template was designed and implemented. Re-audit was done.

Results: A total of 60 operation notes were audited, and of the 20 parameters in the checklist, only 2(10%) were filled up at all times; surgeon’s name and procedure. In the remaining 18(90%) parameters, the value ranged from 0% to 98.3%. Re-audit showed 100% note-taking across all the 20 parameters.

Conclusion: The new proforma for operative notes allowed no room for error or missed entries.

Keywords: Operative notes, Audit, RCS guidelines. (JPMA 70: 491; 2020).

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Introduction

The Royal College of Surgeons (England) emphasises that surgeons "must ensure that accurate, comprehensive, legible and contemporaneous records are maintained of all their interactions with patients".\(^1\)

Operative notes are an account of details of events occurring from patient’s entry into the operating theatre (OT) to their exit after surgery.\(^2\) These serve as a reference tool for future references whenever healthcare professionals confront patients with surgical history. Apart from being a record of history, these notes might need to be reviewed in case of litigation issues.\(^2,3\) Moreover, OT notes are an important part of medical records that prove to be a valuable tool for researchers.

Many a study has been conducted all around the world regarding accuracy, completeness, validity, legibility, reliability and correctness of medical/OT notes. Results showed poor quality of medical record-keeping.\(^2,4\) The Royal College of Surgeons (England) established guidelines regarding documentation of operative notes in 2008.\(^1\)

The current study was planned to determine whether the guidelines were being followed at our institution, and what could be done to improve the quality of note-keeping.

Materials and Methods

The retrospective study was conducted at the Pakistan Institute of Medical Sciences (PIMS), Islamabad, Pakistan, and comprised audit of consecutive General Surgery elective OT notes from October 2015 to November 2015 according to the Royal College of Surgeons (England) guidelines 2014. Data included surgeries for upper gastrointestinal tract (GIT), colorectal, breast and endocrine, vascular and hernia. The specific criteria on which the notes were judged was based on the Good Surgical Practice guidelines 2014.\(^1\) Data was collected on a generated checklist (Appendix-A).

The results were presented in a departmental meeting in the General Surgery ward. Doctors were educated about the guidelines and the details to be included in the operative notes. A new detailed OT notes proforma, including 20 important categories (Appendix-B) was established based on the guidelines\(^1\) and implemented.
Re-audit was done in December 2015, whereby operative notes of 60 consecutive patients were examined. A similar data collection checklist was used. Statistical analysis, including paired t-test, was performed.

Results

A total of 60 operation notes were audited, and of the 20 parameters in the checklist, only 2(10%) were filled up at all times; surgeon’s name and procedure. In the remaining 18(90%) parameters, the value ranged from 3.3% to 98.3% (Table). The difference between audit and reaudit was statistically significant (p<0.001) (Figure).

Discussion

OT notes are an important part of clinical course, and good-quality, accurate, precise and well-structured notes may prove helpful in several situations, for example, future reference by a physician,2 medico-legal2,3 or research purposes. The Royal College of Surgeons (England) established guidelines for a complete OT notes proforma in the Good Surgical Practice guidelines 2014.1 Strict adherence to a standard set of guidelines improves medical record-keeping and reduces chances of error. Literature lists a number of studies from General Surgery as well as sub-specialties, showing poor quality of
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Figure: Entry percentages during Audit and Re-audit.

Figure: Graphical Representation of Audit 1 and 2 Data Entry Percentages

References


Conclusion

Accuracy and legibility of operative notes are key aspects of patients’ medical record-keeping which provides valuable information for all future references. Operative notes at the study site were not in accordance with relevant guidelines, and the new proforma was found to be just about perfect, with no room for error or missed entries.

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